DISCUSSION OF PAPER BY GEORGE E. CARTMILL: PUBLIC-PRIVATE PARTNERSHIP: ITS IMPACT UPON HOSPITALS AND RELATED HEALTH-CARE INSTITUTIONS*

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So that you can be on guard, I ought to tell you that I wrote a book last year which concerned some of the medical affairs that we are discussing here, and that it was reviewed a few weeks ago in the *Journal of the American Medical Association*. The reviewer was a man whom I do not know and who does not know me. He said he thought I was competent as an observer of medical affairs and that my observations in this instance were on the whole fair to all parties concerned.

At about the same time the same book was reviewed in *Medical World News*, with which some of you are familiar and which is owned by the same company that employs me. In this case the reviewer was Dr. Morris Fishbein, whom many of you know. I have known Dr. Fishbein for nearly 30 years, and he has known me for nearly 30 years. Dr. Fishbein in his review said, among other things, that I was "uninformed and impertinent."

I am not prepared to say which of these two views may be closer to the truth, but I must say I have a definite preference. I emphasize that what I bring to you here—what I bring to George E. Cartmill, as he well knows—are a reporter's observations, and not the observations of a professional person or an authority in any of the fields with which we are concerned. Sometimes bringing a reporter's observations to a professional group can be hazardous. I talked to a group of doctors out west not long ago and when I finished one of the doctors came up to me and said: "You know, Cunningham, I don't think you're going to have a nervous breakdown, but you sure are a carrier."

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May I say that Midwest General Hospital, beleaguered as it is in Mr. Cartmill's description, represents the best that we have in medical care in the United States; and that if the rest of the health-care establishment were nearly as good as Midwest General, we should not be in the trouble we now face. I should like to comment briefly on several observations made by Mr. Cartmill, and then examine more carefully one aspect of the institution he described.

Mr. Cartmill said, for example, that Midwest General has not accepted primary responsibility for ensuring the existence of other parts of the system. That is stating the situation in the kindest possible terms. I think Midwest General represents the type of hospital that has assumed more responsibility in this respect than most others, but because of the way the system has been working, the hospital position in general may be stated as: "If you don't need everything, you don't need anything."

Mr. Cartmill also referred to one type of care given to both private patients and patients in other categories. He did not explain exactly what he meant by type of care, but I presume he meant high-quality care. For many years it has been a persistent part of the professional mythology that we have just one quality of care and that everybody gets it. This suggests that the patient who is operated on by the chief surgeon with the resident looking on is getting the same quality of care as the patient who is operated on by the resident with the chief surgeon looking on. I think this may be a doubtful proposition, and I think that perhaps we should stop fooling ourselves into thinking that the quality of care is the same. We may get further faster if we understand that everybody is not receiving the same quality of care and is not going to; and we might accomplish more if the goal were providing not the very best care for the largest possible number of patients but the most care for everybody.

One thing in Mr. Cartmill's presentation that I should like to discuss in some detail is consumer representation. We are hearing more and more about this subject. Mr. Cartmill said: "We are in danger of exterminating much that has been good in this country in the name of consumer representation."

I believe that is true. And I suggest that if we achieve anything like true consumer representation in this country in health services or any other field we may have gained a great deal more than we shall have destroyed. We may damage the health service here and there, we may

damage other elements of society here and there in striving to achieve true consumer representation, but we may save our society in the process.

Consider for a minute what has been happening in our universities, where active rejection of institutional values by those for whom the institutional service presumably is designed has become commonplace, and where resistance to authority took the form of physical violence in more than 300 instances in the last year alone. There may have been close to that many yesterday.

It would be absurd to suggest that hospital patients and families and communities stand in the same relation to hospitals and doctors as university students and families and communities do to institutional administrations and faculties. But I think it would be foolhardy to deny that there are some similarities, and some hospitals in some of our distressed areas particularly are quite ready to believe today that the experience of the universities could be repeated at the hospitals—possibly for reasons that are not altogether dissimilar.

I should explain that my firm publishes a monthly magazine called *College and University Business*, addressed to administrative officials of higher educational institutions. As one of the editors of that magazine I have spent some time during the last 15 months visiting some of the campuses during and following episodes of student rebellion.

We all understand that there are just about as many analysts of campus disorders as there are persons on the campuses, and the opinions about the causes of the student rebellion are as diffuse and divergent as the opinions on how it should be handled. But there are two things that all the analysts agree on, and this may be something to think about as we consider here the problems our hospitals are facing today and are likely to face in the next few years.

First, the student activists and radicals and revolutionaries, whatever their number, would never have succeeded in disrupting university operations had it not been for the fact that a substantial segment of the student population, which some authorities have estimated at as much as 40% of the total enrollment, has been deeply dissatisfied with the relevance of university education and the quality of university life, and has been willing to go along with the demonstrators even when they disapproved or actually feared the tactics that were employed.

Second, the analysts have agreed in most cases that the governing

authorities of the institutions have been largely if not wholly out of touch with what was going on among students under their own jurisdictions. They simply didn't believe it could happen.

I suggest that these phenomena are not wholly unrelated to the situation that some hospitals are in today. For example, over the last several years some of the committees and commissions and officials and scholars who have been examining hospital problems have been recommending, among other things, that consumers should be represented in our planning processes and on our governing authorities. Here and there these suggestions have been received with some acquiescence, but for the most part they have either been ignored or rejected by physicians and hospital administrators who ask: "What do laymen know about the kind of health service they should be receiving?"

Some university administrators and faculty members have been asking: "What do students know about the kind of education they should be receiving?" But they are not asking this question as often as they were a year ago. Some urban hospitals have been meeting systematically with neighborhood representatives to determine needs and plan services accordingly, and they have reported some interesting experiences. Sometimes the experiences have been traumatic; some of the neighbors, like some of the students, are pretty hard to take. They have become so completely disaffected, so alienated from the system, that all they want to do is destroy it. They insist on unreasonable change; they want control, not just a voice. They are the community's equivalent of the student radicals and revolutionaries, threatening not so much because of what they are demanding but because they could be joined by thousands of others who are dissatisfied but not yet radical in their demands. Like the colleges, the neighborhoods conceivably could be radicalized if we reject them out of hand and refuse to make any changes or accommodations whatsoever.

As you all know, some hospitals that have reached out into their communities in the last year or two have had a different kind of experience. Sometimes the neighbors have known much more about what kind of services they needed, and had better ideas on how the services should be provided, than anybody had ever thought possible. "We are finding out that there is a lot of ability there," one university administrator, said, following a series of confrontations with the the university hospital's ghetto neighbors. The same administrator in the same discussion

also observed that "this country is at a point where the provision of health care is a public utility, and the professionals are going to be ousted from making the decisions."

Whether the professionals are going to be ousted remains to be seen, but I think most of us today understand that the professionals are no longer making all the decisions all by themselves. And whether they keep their present influence on decisions may depend on how well the professionals can accommodate consumer values and offer services that meet the test of relevance.

What does this mean?

As the term has been used in the discussions and turmoil at the universities, relevance does not mean that anybody thinks the university should stop teaching Plato and Shakespeare and turn the entire curriculum over to Afro-American courses, or that all the professors should grow beards and wear sandals and smoke marijuana with the students. What the complaints about relevance do mean is that the critics, especially the students, are repelled by computerized admissions offices, indifferent counselors, research-oriented teachers, rigid curricular requirements, and what they see as phony gestures toward recognition of the fact that students are adults. Many students feel, in short, that—as some of them have expressed it—they are being programmed rather than educated.

Well, we have computerized admissions offices in hospitals, and certainly we have bored and indifferent counselors, some research-oriented doctors and nurses, and rigid procedures, and if we had some phony gestures toward recognition of patients as adults we should at least have some gestures, and that—in more cases than not—would be an improvement.

I don't recall hearing any patients say they felt they were being programmed rather than treated, but that may be only because hospital patients lack the gift for felicitous phraseology that some university students have. Certainly the phrase expresses very well what many patients have been trying to tell us.

Are we listening?

Let me make clear here that I am not referring simply to the absence, or at any rate to the plainly diminishing incidence, of what we used to call tender loving care. I think most people understand that today's specialization and technology make highly personalized care diffi-

cult and sometimes impossible to achieve. The complaints about relevance are not pleas for backs to be rubbed and hands to be held. Rather, I think, they enjoin physicians and hospital administrators and other professionals to consider the whole problem, and not just their own disjunctive segments of the problem.

Medical care isn't relevant, for example, when an elderly woman in marginal circumstances is treated and cured of pneumonia in a fine modern hospital, such as Midwest General, and then discharged to return to the same unheated flat where she contracted the pneumonia. Relevance is not especially honored either when a surgical patient with obvious psychopathic symptoms is admitted, diagnosed, operated on, and discharged without any attention to the psychiatric problems. Nor is relevance notably accomplished when a patient is put to bed in a hospital for 72 hours at $65 a day just so he can be put through a few tests and Blue Cross will pay the bill.

Obviously it isn't likely that hospital patients are going to get out of bed and march downstairs to the administrator's office or upstairs to the chief surgeon's office, carrying signs and making demands. In fact, it isn't likely that many patients are even aware that a lot of the care they are getting doesn't meet the test of relevance by today's standards. The thing that should concern us and does concern us is that all the patients' dissatisfactions with what happens to them at hospitals come to focus on something they do understand: what it all costs. Another thing that should concern us is that a lot of elective and appointed public officials in the Congress and the federal departments and the state legislatures and state houses do understand that there is a direct connection between cost and relevance.

This concern has been apparent, as we all know, in the *Report to the President on Medical Care Prices* in 1967, and in the National Conference on Medical Costs, in 1967, and in the report of the National Commission on Health Manpower in 1967, and the report of the Secretary's Advisory Committee on Hospital Effectiveness in 1968, and the National Commission on Health Facilities in 1968. I understand the same concern was apparent in the report to the new administration of its own task force on health-care problems in 1969.

What has been the response of the health professions to these indications of public concern about the relevance of health care in the United States today? I think we're all familiar with what the response has been.

Hats were not exactly thrown in air, for example, over the opportunity to fund neighborhood clinics through the Offices of Economic Opportunity, or over the opportunity to advance the cause of relevance through such programs as the Regional Medical programs for heart disease, cancer, and stroke.

Another observable response was that when the American Hospital Association, after two years of study led in large part by Mr. Cartmill, issued a new policy statement on the financial requirements of health-care institutions and services, looking toward a system of reimbursement by contracting agencies that would compel attention to relevance by rewarding it financially and penalizing its absence, an uproar followed. This delayed approval of the policy for nearly a year while hospital administrators and trustees and associations argued that it would invade their autonomy and destroy their independence and they weren't going to let anybody else—not even other hospitals—tell them what was and what wasn't relevant for their own institutions.

Another response from within the profession which was less visible but perhaps most typical came recently from the director of public relations of a well-known teaching hospital who called our office to talk about the hospital's annual report, which he said was then being planned. "The theme is the hospital as a community institution," he said proudly. "Have you any suggestions?"

Well, he was told, you might describe how the hospital has been working with other institutions in the community to integrate planning so that all the needed services could be offered without duplication and overlapping; and you might tell how the hospital had established communications with the nearby population and had planned services accordingly; and you might want to describe the hospital's home-care program, and how it had been working with all the nursing homes in the area. And you might even want to report how you called in air-pollution engineers to study the incinerator system so the hospital could avoid contributing to a public health problem in the area.

The report might also add that the hospital saw the need of giving up some of its precious autonomy in the interest of community planning and relevance by supporting the AHA's new financial policy.

Well, that wasn't exactly what they had in mind. In fact, the director of public relations said the hospital wasn't doing any of those things. What they were thinking of, he said, was to tell how they have

a Santa Claus visit the children's ward at Christmas time with presents for all the children; and how the nurses' glee club gave a concert every year at one of the big churches in the neighborhood; and how the administrator and his assistant went to meetings of all the men's and women's clubs and made speeches about hospital costs; and how they publish a bulletin every month telling about what the doctors were doing, and what the services were and why they cost so much; and how the hospital related to the community by opinion polls asking the patients whether the coffee was hot, and how they liked the food, and how was the temperature of the room, and of course asking for any criticism or suggestions they might have.

Now asking a hospital patient to criticize what has been happening to him always reminds me of an old Hindu proverb that goes something like this: "Before thou fordest the river, O brother, revile not unduly the crocodile's mother." I don't mean to suggest that there is anything that can be said against Santa Claus or glee clubs or speeches by administrators or hospital publications or patients' opinion polls. Certainly these are all legitimate and useful activities, and they have something to do with relevance, but certainly they are not at the core of relevance.

The core of relevance, it seems to me, has to do with comprehending the whole problem and all the problems, and then organizing and ordering the man power and facilities and resources that are appropriate for all the problems. Toward that end, I submit, consumer representation may help more than it will hurt.